Colorado Medicaid Prior Authorization Request Form
Victrelis (boceprevir), Olysio (simeprevir), Incivek (telaprevir)*

This form must be signed by prescriber to request prior authorization for Victrelis, Olysio, or Incivek* beginning October 1, 2014. See the Preferred Drug List (PDL) for details at: https://www.colorado.gov/hcpf/provider-forms. Certain documentation is required to accompany this form for approval consideration. Incomplete forms will not be reviewed.
* Incivek is no longer being manufactured for distribution in the U.S.

Select drug you are requesting: □ **Victrelis** □ **Olysio** □ **Incivek**

Member name: _____ DOB: _____

Medicaid ID: _____ Age: _____ Must be ≥ 18years Gender: _____ Weight: _____ (lbs)

Child-Pugh score _____ Must be < 6 (provide documentation) HCV RNA Pre-treatment _____ (provide documentation)

Does member have Hepatitis genotype (GT) 1? □ No □ Yes (provide documentation)
Olysio only: Does member have GT 1a and NS3 Q80K polymorphism? (provide document) □ No □ Yes

Indicate member's diagnosis(es) (provide documentation): □ Chronic Hepatitis C □ HIV/AIDS

Is member receiving a strong CYP3A4 inducer? (e.g. rifampin, rifabutin, phenytoin) □ No □ Yes
Is member receiving a moderate CPY3A4 inducer? (e.g. carbamazepine, oxcarbazepine, phenobarbital, rifapentine, dexamethasone, certain HIV Protease Inhibitors (PI) and Reverse Transcriptase Inhibitors (RTI), ritonavir, St. Johns Wort) □ No □ Yes
Is member receiving moderate to strong CYP3A4 inhibitor? (e.g. erythromycin, clarithromycin, telithromycin, certain anti-fungals, Stribild®, certain HIV PIs and RTIs, milk thistle, cyclosporine) □ No □ Yes

Prior Treatment: □ No □ Yes Describe: _____

Concurrent therapy with peginterferon alfa and ribavirin □ No □ Yes (provide documentation)
Note a 4-week treatment lead in of peginterferon alfa and ribavirin is required prior to initiation of **Victrelis**.

History of drug/alcohol misuse/abuse? (including medical/recreational marijuana) □ No □ Yes
Has member been drug/alcohol free for at least 6 months? □ No □ Yes

Provide initial drug/alcohol screen documentation for **ALL** clients. Provide random monthly screen documentation if member has a **history of misuse/abuse within the last 2 years**. Form may be used to update test results throughout tx.

Pre-treatment (+/-)____Month 1 _____ Month 2 _____ Month 3 _____ Month 4 _____ Month 5 _____ Month 6 _____

Ribavirin contraindication: Women of childbearing potential and their male partners must use 2 forms of contraception
Female member: Is member of childbearing potential? □ No □ Yes (provide pregnancy test)
Male member: Does member have partner of childbearing potential? □ No □ Yes (provide BC counseling)

Is requested drug being prescribed in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist?
□ No □ Yes Identify provider: _____

Physician: _____ Phone: _____ Fax: _____ NPI: _____

Physician signature: _____ Date: _____

Please fax completed form to 1-888-772-9696

Effective January 1, 2016